State: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The definition and determination of reasonable charge as administered by the Division of Medical Services in establishing rates of payment for medical services will be that charge which most nearly reflects the provider's usual and customary charge to the general public for the service, as qualified by application of available prevailing charge resources and the upper and lower limitations of payment stipulated or optionally provided in Federal regulation.

If the funds at the disposal or which may be obtained by the Division of Medical Services for the payment of medical assistance benefits on behalf of any person under one or more of the following specific medical services reimbursement methods, shall at any time become insufficient to pay the full amount thereof, then, pursuant to state law, the amount of any payment on behalf of each of such persons shall be reduced pro rata in proportion to such deficiency in the total amount available or to become available for such purpose. In accordance with requirements of Title 42, Code of Federal Regulations, 447.204, the agency's payments will not be reduced beyond the point at which they become insufficient to enlist enough providers so services under the plan are available to recipients at least to the extent that those services are available to the general population.

PHYSICIAN, DENTAL AND PODIATRY SERVICES

Physician Services (includes doctors of medicine, osteopathy, podiatry, dentistry).

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the Division of Family Services. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CFR 447 Subpart D. Agency payment will be the lower of:

(1) The provider's actual charge for the service; or

(2) The allowable fee based on reasonable charge as above determined.

For certain specified diagnostic laboratory services included under the Title XVIII Medicare fee schedule, and when provided in a physician's place of service, Medicaid payment will not exceed the maximum allowable Medicare payment.

Payment for physician services for those organ and bone marrow transplant services covered as defined in Attachment 3.1-E will be made on the basis of a reasonable charge determination resulting from medical review by the Medical Consultant.

The state agency will reimburse providers of Physician's Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

STATE: Missouri

OPTOMETRIC SERVICES

The state agency will establish fee schedules based on the reasonable charge for the services as defined and determined by the Division of Medical Services. The determination and reimbursement of reasonable charge will be in conformance with the standards and methods as expressed in 42 CRF 447 Subpart D. Agency payment will be the lower of:

(1) The provider's actual charge for the service; or

(2) The allowable fee based on reasonable charge as above determined.

The state agency will reimburse providers of any Optometric Services as may be covered under Medicare Part B, to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

I. Outpatient Hospital Services Reimbursement for Hospitals Located Within Missouri.

A. Outpatient hospital services, unless otherwise limited by rule, shall be reimbursed on an interim basis by Medicaid at the lesser of sixty-eight percent (68%) of usual and customary charges as billed by the provider for covered services or ninety percent (90%) of the facility's Medicaid-allowable cost-to-charge ratio as determined by B., or C., of this subsection using the most recent fiscal year-end cost report. Reimbursement at the applicable percentage shall be effective January 4, 1994 for all providers and shall be subject to adjustment whenever the inpatient rate is changed.

1. All services provided to GR recipients will be reimbursed from the Medicaid fee schedule in accordance with provisions of 13 CSR 70-2.020.

2. Effective for dates of service September 1, 1985, and annually updated, certain clinical diagnostic laboratory procedures will be reimbursed from a Medicaid fee schedule which shall not exceed a national fee limitation.

3. Services of hospital-based physicians and certified registered nurse anesthetists shall be billed on a HCFA-1500 professional claim form and reimbursed from a Medicaid fee schedule or the billed charge, if less.

B. The state agency shall review audited Medicaid-Medicare cost reports for each hospital's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the hospital's net reimbursement (except for those hospitals identified in subsection C., of this section) shall be in amounts representing not more than ninety percent (90%) of the lesser of-

1. Reasonable costs as determined by the state agency's annual review of the participating hospital's outpatient fiscal year-end cost reports and reconciliation of the Medicaid allowable charges and reimbursement for Medicaid services provided during that fiscal year; or

2. Usual and customary charges as billed by the provider of services and as representing a prevailing charge in the locality for comparable services under comparable circumstances.

C. All facilities which meet the Medicare criteria for exemption from the lower of cost or charge limitation as nominal charge providers for fiscal year cost determination shall have their net reimbursement determined at no more than one hundred percent (100%).

D. Within ninety (90) days following the receipt of the complete unaudited Medicaid-Medicare cost report filed by the provider in accordance with V.A. of the inpatient hospital services reimbursement plan, interim outpatient settlements for facilities having a fiscal year-end subsequent to January 1, 1984 will be done after desk review of the report for only the following hospitals:

1. High volume Medicaid hospitals that serve a disproportionate number of low income recipients and meet the criteria defined in VI.A.2., and 3., of the inpatient hospital services reimbursement plan. Interim settlements will be at not more than one hundred percent (100%) of the lower of unaudited costs of usual and customary charges for covered services; and

2. Hospitals as defined in section C., Interim settlements will be at not more than one hundred percent (100%) of cost. A letter from Medicare attesting to the exemption must accompany the cost report.

E. For reporting purposes in the outpatient Medicaid data, facilities shall not include services reimbursed from a fee schedule, which include services to GR recipients, the clinical diagnostic laboratory services as identified on page 2a of attachment 4.19-B, and services of hospital-based physicians and certified registered nurse anesthetists.

F. Medicaid outpatient cost settlements will be determined utilizing a total outpatient cost-to-charge ratio derived for each facility by treating the facility's total outpatient services (ancillary, emergency room and clinic) as one (1) single, combined department.

G. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

1. Reasonable costs as determined by the state agency's annual review of the participating hospital's outpatient fiscal year-end cost reports and reconciliation of the Medicaid allowable charges and reimbursement for Medicaid services provided during that fiscal year; or

2. Usual and customary charges as billed by the provider of services and as representing a prevailing charge in the locality for comparable services under comparable circumstances.

C. All facilities which meet the Medicare criteria for exemption from the lower of cost or charge limitation as nominal charge providers for fiscal year cost determination shall have their net reimbursement determined at no more than ninety percent (90%) of cost.

D. Within ninety (90) days following the receipt of the complete unaudited Medicaid-Medicare cost report filed by the provider in accordance with V.A. of the inpatient hospital services reimbursement plan, interim outpatient settlements for facilities having a fiscal year-end subsequent to January 1, 1984, will be done after desk review of the report for only the following hospitals:

1. High volume Medicaid hospitals that serve a disproportionate number of low income recipients and meet the criteria defined in V.F.2.(C) of the inpatient hospital services reimbursement plan. Interim settlements will be at not more than ninety percent (90%) of the lower of unaudited costs of usual and customary charges for covered services; and

2. Hospitals as defined in section C., Interim settlements will be at not more than ninety percent (90%) of cost. A letter from Medicare attesting to the exemption must accompany the cost report.

E. For reporting purposes in the outpatient Medicaid data, facilities shall not include services reimbursed from a fee schedule, which include services to GR recipients, the clinical diagnostic laboratory services listed in paragraph (11)(A)2. and services of hospital-based physicians and certified registered nurse anesthetists.

F. Medicaid outpatient cost settlements will be determined utilizing a total outpatient cost-to-charge ratio derived for each facility by treating the facility's total outpatient services (ancillary, emergency room and clinic) as one (1) single, combined department.

G. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII.

State: Missouri

OUTPATIENT HOSPITAL SERVICES - OUT-OF-STATE HOSPITALS AND FEDERALLY-OPERATED HOSPITALS LOCATED WITHIN THE STATE OF MISSOURI

1. Out of state outpatient hospital services and services of federally-operated hospitals located within the state of Missouri will be reimbursed by Missouri Medicaid at sixty percent (60%) of usual and customary charges as billed by the provider for covered services with the exceptions specified in paragraphs 13 CSR 70-15.010 (12)(A)1., 2, 3, and 4.

2. Payments on claims submitted, unless otherwise specified, constitute final payment on those claims to hospitals located outside the state of Missouri and to federally-operated hospitals located within the state of Missouri and no year-end cost settlements will be done.

3. Outpatient hospital services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the deductible and coinsurance as imposed under Title XVIII. ✓

LAB AND X-RAY SERVICES (INDEPENDENT)

The state agency will establish fee schedules based on reasonable charges for services as defined and determined by the Division of Medical Services in accordance with the methods and standards of 42 CFR 447 Subpart D. The agency payment will be the lower of:

1. The provider's actual billed charge, or;

2. The allowable fee based on reasonable charge as above determined.

For certain specified diagnostic laboratory services included under the Title XVIII Medicare fee schedule the Medicaid payment will not exceed the maximum allowable Medicare payment.

The state agency will reimburse providers of Lab and X-Ray Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility. ✓

FAMILY PLANNING

The state agency will pay for medical services which are identified as qualified Family Planning services. The payment will be in accordance with the standards and methods herein described as apply to the provider type represented.

State: Missouri

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (E.P.S.D.T.)

Reimbursement for EPSDT services provided in accordance with the provisions of section 6403 of P.L. 101-239 and federal regulations as promulgated thereunder shall be made on the basis of reasonable allowance fee schedules or per-diem rates, if applicable, as determined by the Division of Medical Services, and in accordance with the standards and methods herein described as applicable to the service and provider type represented. The state payment for each service will be made on the lower of:

(1) The provider's actual charge for the service, or;

(2) The maximum allowable fee or rate as determined by the Division of Medical Services.

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EMERGENCY AMBULANCE SERVICES

The state agency will establish rates for reimbursement which are defined and determined as reasonable by the Division of Medical Services in accordance with 42 CFR 447 Subpart D. Reimbursable elements of service shall be a basic service charge, specified ancillaries, and a specified allowance for mileage. Payment will be based on the lower of:

1. The provider's actual charge, or;
2. The reasonable rate as determined above.

The state agency will reimburse providers of Emergency Ambulance Services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility.

HOME HEALTH SERVICES

The state agency will establish rates for reimbursement as defined and determined by the Division of Medical Services in accordance with 42 CFR 447 Subpart D and state regulation 13 CSR 70-90.020. Payment will be based on the lower of:

(A) The provider's billed charge for the service; or

(B) The Title XVIII interim Medicare rate in effect as of the date of service as determined by the Medicare fiscal intermediary; or

(C) The Medicaid maximum allowable fee for service.

DRUG SERVICES

The state agency will utilize the definitions, standards and methods described in 42 CFR 447.301 and 447.331 through 447.334 in establishing payment rates for prescribed drugs on the Missouri drug list.

Reimbursement for multiple source drugs selected by HCFA will be made at the lower of the -

(A) Usual and customary charge as billed by the provider; or

State Missouri

(B) Price(s) included on the Drug Pricing File which are derived from one (1) or more of the following:

1. Average Wholesale Price (AWP) as furnished by the state's contracted agent less 10.43 percent; or

2. Federal upper limit.

Reimbursement for selected speciality drug products provided from May 1, 2000 through December 31, 2000, will be made at the lower of the -

(A) Usual and customary charge as billed by the provider; or

(B) Price or prices included on the Drug Pricing File which are derived from one or more of the following:

1. The Average Wholesale Price (AWP) in effect on April 30, 2000, as provided by the state's contracted agent, less 10.43 percent; or

2. Missouri Maximum Allowable (MMAC or "Mini-MAC) as determined by the state agency.

Reimbursement for other covered drugs will be made at the lower of the -

(A) Usual and customary charge as billed by the provider; or

(B) Price or prices included on the Drug Pricing File which are derived from one or more or the following:

1. Average Wholesale Price (AWP) as furnished by the state's contracted agent less 10.43 percent; or

2. Missouri Maximum Allowable (MMAC or "Mini-Mac") as determined by the state agency for selected multiple-source drugs.

The professional dispensing fee permitted will be the applicable fee at the time the prescription is being filled.

State Missouri

The annual assurance is given that, for the period October 1, 1998, through September 30, 1999, the requirements of State Medicaid Manual 6305.1.A. and 6305.2 are met. In the aggregate, Missouri's Medicaid expenditures for multiple source drugs identified and listed in accordance with 42 CFR 447.332(a) are in accordance with the upper limits specified in 42 CFR 447.332(b).

The triennial assurance is given that the requirements of State Medicaid Manual 6305.1.B. and 6305.2 are met. In the aggregate, Missouri's Medicaid expenditures for "other drugs" are in accordance with limits specified in 42 CFR 447.331(b).

State MISSOURI

Medical Equipment Services

2-25-92 per Jerri Plonka - eyeglasses & dentures are considered to be prosthetic devices.

The state agency will reimburse Durable Medical Equipment, orthotic and prosthetic devices, rehabilitative training, hearing aids and audiological services in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for each service will be the lower of:

(1) The provider's actual charge for the service, or;
(2) The allowable fee based on reasonable charge as above determined.

The state agency will reimburse providers of Durable Medical Equipment, orthotic and prosthetic devices, rehabilitative training and any such Medicare covered audiological services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility. ✓

Rural Health Clinic Services

Rural Health Clinic services will be reimbursed using the methods established under the Medicare Program. Ambulatory services provided but not covered under the Rural Health Clinic Program will be reimbursed on a fee-for-service basis using rates established by the state agency.

Ambulatory Surgical Care Clinics

The state agency will reimburse Ambulatory Surgical Care providers for covered surgical procedures and related ancillaries in accordance with the provisions of 42 CFR 447 Subpart D. The state payment for service will be made on the lower of:

(1) The provider's actual charge for the service, or;
(2) The Medicaid maximum allowable fee under the established all-inclusive rate.

The state agency will reimburse providers of Ambulatory Surgical Care services to the extent of the deductible and coinsurance as imposed under Title XVIII for those Medicaid eligible recipient-patients who also have Medicare Part B eligibility. ✓

Nurse-Midwife Services

The state agency will reimburse providers of nurse-midwife services the lower of the provider's usual and customary charge to the general public or the Medicaid maximum allowable amount. For those services reimbursable as nurse-midwife services, the maximum allowable amount will be the same as the physician fees applicable to comparable services.